



MARYLAND
Department of Health

**Maryland Medicaid Electronic Health Records (EHR)
Incentive Program
Registration and Attestation**

**Electronic Medicaid Incentive Program Payment (eMIPP)
Provider User Guide**

**Version 6
2018**

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Provider User Guide

Introduction

To facilitate enrollment in the Maryland Medicaid Electronic Health Record (EHR) Incentive Program, Maryland utilizes the electronic Medicaid Incentive Program Payment (eMIPP) system. eMIPP is our registration and attestation portal. This document outlines the necessary requirements and steps for providers and hospitals to attest to the EHR Incentive Program.

If you are a hospital representative seeking to attest with Maryland, please signal your intent to participate by emailing mdh.MarylandEHR@maryland.gov. Although general information about accessing, registering, and attesting in eMIPP is provided in this document, additional instructions for hospital participation will be provided on an individual basis.

Hospitals will not be paid by Maryland until they have signaled their intent to register and attest by emailing the State at mdh.MarylandEHR@maryland.gov.

All other providers please follow the instructions listed below.

Getting Started

Please note that **Program Year (PY) 2016 was the last year to begin participation** in the Maryland Medicaid Electronic Health Record (EHR) Incentive Program. If you have not participated and received payment in the EHR Incentive Program prior to 2016, you are not eligible to begin receiving payment. If you have participated in PY 2016 or prior, and received an initial payment, you are eligible to continue participation for a total of 6 years or until the program ends in 2021. Be advised that providers are not obligated to participate in consecutive years; however they must have initiated participation no later than 2016.

To qualify to register with the Maryland Medicaid Electronic Health Record (EHR) Registration and Attestation System, providers must complete the following steps:

Step 1: Verify Eligibility and Register with CMS

- a. Verify eligibility to participate in the EHR Incentive Program – read the information available on the [Eligibility Tab](#) on our webpage.
- b. Register with the Centers for Medicare and Medicaid Services (CMS) – go to <https://ehrincentives.cms.gov/hitech/login.action>. For help with registration please use the [user guide](#).
- c. **Note:** At the completion of CMS-level registration, providers will receive a CMS registration ID number. Save this number; you will need it to complete eMedicaid enrollment and when logging into eMIPP.

Step 2: Verify Enrollment in Maryland Medicaid FFS and eMedicaid

- a. To participate in the Maryland Medicaid EHR Incentive Program, all providers must be enrolled with Maryland Medicaid Fee-for-Service. Although all providers must be enrolled in Maryland Medicaid Fee-for-Service, they do not need to participate in the Fee-for-Service program. If you do not know if you are registered as a Maryland Medicaid Fee-for-Service provider, or if you would like to register, visit Maryland Medicaid's new **electronic Provider Revalidation and Enrollment Portal (ePREP)**. ePREP is a one-stop shop for provider enrollment, re-enrollment, revalidation, and information updates. If providers need assistance with ePREP, they can call ePREP's call center at 1.844.4MD.PROV (1.844.463.7768). The ePREP help line can help providers with general enrollment issues and has limited knowledge about the EHR Incentive Program.
- b. Maryland also requires providers enroll in eMedicaid, Maryland Medicaid's provider web service portal. You can verify or create an eMedicaid account by going to <https://encrypt.emdhealthchoice.org/emedicaid/>. When registering with eMedicaid, you will need your CMS registration ID. It is very important that you remember your username, password and CMS Registration ID used during this step as it will be the same credentials used when logging into eMIPP. If you have any problems enrolling in eMedicaid, contact Provider Enrollment at (410) 767-5340.

Step 3: Proceed to the State Registration and Attestation Portal (eMIPP)

- a. Providers can access eMIPP here: <https://emipp.health.maryland.gov/>.

Browser Requirement

eMIPP is designed to be accessed through all major browsers including Chrome, Internet Explorer 11 (IE11), and Firefox. The site is best viewed in Google Chrome.

Register for the EHR Incentive Program

Log In

Before logging into eMIPP, providers will need the following information

- a. CMS Registration ID # (see Step 1b)
- b. Maryland eMedicaid Username AND Password (see Step 2b)

If you do not have this information, you will not be able to successfully log into eMIPP. To log into eMIPP visit <https://emipp.health.maryland.gov/>.

Keep in mind that the eMedicaid username, password and the CMS Registration ID entered during Step 2b must match what is entered in eMIPP. If the combination does not match, you will receive an error message when trying to attest. If you get an error message, please check to make sure you entered the correct information. If the problem persists, it is likely that your eMedicaid profile is not associated with the individual National Provider Identifier (NPI) that you used to enroll with CMS for participation in the EHR Incentive Program (Step 1b).

Problems with your [eMedicaid](#) account can be addressed by calling Provider Relations at (410) 767-5503.

Eligible Professional Registration and Attestation in eMIPP

1. Login with eMedicaid username and password and click **submit**.
2. On the next screen, select **Go**.
3. Under eMIPP Registration, select **Start**.
4. Enter your 10-digit CMS Registration ID; select **Search**. (Figure 1.)
5. On the next screen, you will see a page with multiple tabs. By default, you will begin on the **FEDERAL INFORMATION** tab.

Figure 1: Eligible Professional CMS Registration ID



The screenshot displays the eMIPP web portal interface. At the top, there is an orange navigation bar with four tabs: 'Home', 'Register', 'Track', and 'Logout'. Below this, the main content area is divided into two sections. On the left, there is a 'Find Registration' section with a magnifying glass icon and text that reads: 'Enter your CMS Registration ID to begin your EHR Medicaid Incentive Payment Program (EHR MIPP) registration process.' On the right, there is a search form with the label 'Enter CMS Registration ID' followed by a text input field. Below the input field is an orange 'Search' button.

Federal Information Tab

On this tab, you need to review and confirm this information. The information is available by clicking on the icon that corresponds with the Program Year for which you are attesting.

Figure 2: Eligible Professional Accessing Federal Information Screen

Payment Year	Program Year	Payee NPI	Provider Type
4	2015	1111111111	EP - Medicaid
3	2014	1111111111	EP - Medicaid
2	2013	1111111111	EP - Medicaid
1	2011	1111111111	EP - Medicaid

The information on this tab is the exact information you entered with CMS. If there are any issues with the information that need to be corrected, **STOP** and go back to CMS and correct the issue(s). Please wait approximately 24 hours before accessing eMIPP again. If the updated information is displayed, you can continue. If not, wait one more day and try again. If the new information is still not displayed, call the CMS EHR Incentive Program Information Center. The hours are as follows:

7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.

1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

Figure 3: Eligible Professional Federal Information

The screenshot shows a window titled "Federal Information" with a close button in the top right corner. The window is divided into four main sections: "Personal Info", "Address", "Identifiers", and "Exclusions".

Personal Info

First Name	: John
Middle Initial	: Mid
Last Name	: Doe
Suffix	:
Provider Type	: Physician
Provider Specialty	: PEDIATRIC MEDICINE

Address

Address	: 1 Address
City	: My City
State	: MD
Zip	: 21111
Phone	: (301) 111-4444
Ext	: 21
E-mail	: myemail@email.com

Identifiers

The Tax Identification Number (TIN) captured below will receive the EHR incentive payment.

Payee NPI	: 1111111111
Payee Tax ID	: 999999999

Exclusions

Code	Description	Date
No Exclusions Found.		

At the bottom left of the window is a "Close" button.

NOTE: Maryland will use the e-mail address listed in the Federal Information tab (Figure 3) as the primary means of contact with you. Please make sure this is a valid e-mail address and that the inbox it is associated with is frequently monitored.

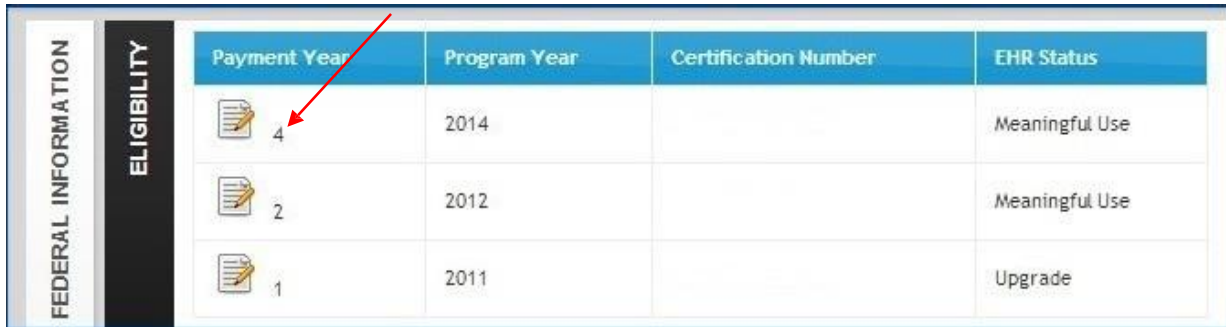
After reviewing the information on Tab 1, click on Tab 2, **ELIGIBILITY** tab.




Eligibility Tab

All providers must attest to meeting eligibility criteria for participation in Medicaid EHR Incentive Program. This must be completed every year of participation.

1. In Tab 2: **Eligibility**, click on the **Payment Year Icon** for the most-recent program year to add your EHR eligibility details.

Figure 4: Eligible Professional Accessing Eligibility Information Screen



FEDERAL INFORMATION	ELIGIBILITY	Payment Year	Program Year	Certification Number	EHR Status
		 4	2014		Meaningful Use
		 2	2012		Meaningful Use
		 1	2011		Upgrade

2. **Enter Eligibility Information.** (Refer to the six scenarios on pages 13 - 18 for more information on filling out this section.)

Figure 5: Eligible Professional Entering Eligibility Information

Eligibility Information

Bold fields are required.

Patient Volume Reporting Period

Start Date(mm/dd/yyyy):

?

End Date(mm/dd/yyyy):

?

Pay To Provider

Select Pay To Provider

The Pay To Provider represents the Maryland Medicaid account to which the incentive payment will be directed upon approval. If no options are available for selection, or if the options available for selection are incorrect, please email mdh.marylandehr@maryland.gov

Eligible Patient Volume

Select yes to eligible patient volume option(s) that apply to you. If not applicable, select no.

Practice as a Pediatrician

?

☒ Yes

☐ No

Practice as a Physician Assistant

?

☐ Yes

☒ No

Hospital Based Provider

?

☐ Yes

☒ No

Include Organization Encounters

?

☐ Yes

☒ No

Render care in FQHC/RHC

?

☐ Yes

☒ No

Include MCO Encounters

?

☐ Yes

☒ No

Total Encounters:

?

Medicaid Encounters:

?

Did you include no-cost encounters?

?

☐ Yes

☒ No

Include encounters outside MD

?

☐ Yes

☒ No

EHR Certification Information

EHR Status

?

☒ MU

EHR Certification Number:

?

MU Reporting Choice

?

Stage 3

Email: mdh.marylandehr@maryland.gov

Save

Cancel

Note: Throughout this screen, any of the “?” icons can provide a pop-up tip for that item. Place your mouse over the icon and a pop-up tip will display.

Patient Volume Reporting Period: Enter the start date (in MM/DD/YYYY format) that you want to start your eligibility reporting period. **This is not your Meaningful Use reporting period;** it is the consecutive 90-day period in the prior calendar year that you are reporting your eligible/Medicaid patient volume. Once you fill in the start date, click in the end date field and the system will automatically fill in the end date. Both the start and end date must be in the prior calendar year—it cannot span multiple years. Your reporting period can be any consecutive 90-day period within the prior calendar year.

Select Pay To Provider: Providers may assign their incentive payment to themselves or reassign it to a Tax Identification Number (TIN) associated with an employer or entity with

which they are affiliated with in the Medicaid Management and Information System (MMIS). Relationships established in MMIS during Medicaid provider enrollment in ePREP are valid pay-to entities that an attesting provider may select in eMIPP. If you do not see the entity you want to reassign the payment to in the drop down list, please log in to [ePREP](#) to see which groups you are affiliated with. If you are not affiliated with your desired pay-to entity, you will have to add an affiliation with the group in ePREP. Providers can call 1.844.4MD.PROV (1.844.463.7768) for assistance with enrollment issues and their ePREP account. If you need further assistance resolving your pay-to entity issue, please contact mdh.marylandehr@maryland.gov with your NPI, your individual pay-to Medical Assistance (MA) number, and your group pay-to MA number.

Eligible Patient Volume: All providers must also complete this section; however, depending on how you answer the questions you will be prompted for slightly different information.

If yes, check all the boxes that apply. You must check at least one of the first three to be considered eligible.

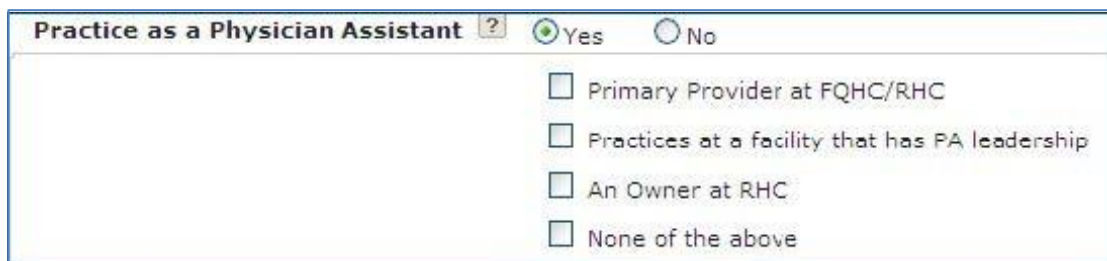
Practice as a Pediatrician: Only select this option if you are a Pediatrician.

Practice as a Physician Assistant: Only select this option if you are a Physician Assistant (PA) who practices predominantly in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is “PA-led.” In Maryland, “PA-led” has the following meanings:

1. When a PA is the primary provider in a clinic (for example, when there is a part-time physician or full-time PA); or
2. When a PA is a clinical or medical director at a clinical site of practice.

If you think you are a PA that meets one of these requirements, you must contact Maryland Medicaid at mdh.MarylandEHR@maryland.gov before continuing with registration.

Figure 6: Eligibility Information for Physician Assistant



Practice as a Physician Assistant ? ☒ Yes ☐ No

☐ Primary Provider at FQHC/RHC

☐ Practices at a facility that has PA leadership

☐ An Owner at RHC

☐ None of the above

Hospital Based Provider: Only select this box if you rendered any care in a hospital setting during the reporting period. MDH defines hospital-based providers as a provider who furnishes 90 percent or more of covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The percentage determination is made based on the total number of Medicaid encounters during the provider's reporting period.

When you select “yes,” an additional question will appear asking for the numbers of encounters in the hospital setting. In order to be eligible to participate in the Medicaid EHR Incentive Program, you must have less than 90 percent of your covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The only exception is for providers practicing predominantly in an FQHC or RHC.

Figure 7: Eligibility Information for Hospital-Based Provider Determination

Hospital Based Provider ? ☒ Yes ☐ No

Total Inpatient Discharges: ?

Medicaid Inpatient Discharges: ?

Medicaid ER Encounters: ?

Total ER Encounters: ?

Depending on how you answer **Include Organization Encounters**, **Render Care in FQHC/RHC**, and **Include Managed Care Encounters**, you will be asked for different encounter volume items. Each of the scenarios is explained below.

Scenario 1:

Include Organization Encounters = **No**

Render Care in FQHC/RHC = **No**

Include MCO Encounters = **No**

Figure 8: eMIPP Default Eligibility Scenario

Eligible Patient Volume

Practice as a Pediatrician	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Practice as a Physician Assistant	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Hospital Based Provider	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Include Organization Encounters	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Render care in FQHC/RHC	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Include MCO Encounters	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No

Total Encounters: ?

Medicaid Encounters: ?

Did you include no-cost encounters?	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Include encounters outside MD	<input type="checkbox"/> ?	<input type="radio"/> Yes	<input checked="" type="radio"/> No

This is the simplest scenario. Enter your total encounters (all payers, all locations) and your Medicaid encounters in the provided fields.

Scenario 2:

Include Organization Encounters = **Yes**

Render Care in FQHC/RHC = **No**

Include MCO Encounters = **N/A**

Figure 9: Selection Criteria for Choosing “Group Proxy”

The form is titled "Include Organization Encounters" with a question mark icon. It has two radio buttons: "Yes" (selected) and "No". Below this is a section titled "Organization NPI" with a text input field and a question mark icon. Below that is a section titled "Render care in FQHC/RHC" with two radio buttons: "Yes" and "No" (selected). Below this are two text input fields: "Total Encounters:" and "Medicaid Encounters:", each with a question mark icon.

Under this scenario, you are electing to use your Practice/Organization’s encounter numbers as a proxy. This is optional. You will need to provide the group or organization NPI that you are using as a proxy and the Practice/Organization’s encounter numbers. If you are choosing to use the “group proxy” approach to determine patient volume, you need to pool all the encounters for the entire group, including those who are not eligible provider types for participation in the EHR Incentive Program. Further, if you choose the “group proxy,” no individual group member can apply for an EHR Incentive using their individual patient volume. Either the whole group participates using the group proxy or no one does.

To ensure that Medicaid has collected all group members before reviewing your attestation, you should upload your group roster for the patient volume period (see page 10). If you do not upload your roster, Medicaid will contact you via the email address available under the "Federal Information" tab (see page 8).

In some cases, Maryland Medicaid may instruct you to enter your group NPI, even if you are not choosing to use the “group proxy” approach. This is to ensure that Medicaid collects all available Medicaid encounters for a particular provider under the group.

Note: “Include MCO Encounters” is not a viable option in this scenario; however, you can still calculate your patient volume with your Managed Care Organization (MCO) encounters. You should include MCO encounters when calculating total and Medicaid encounters.

Scenario 3:

Include Organization Encounters = **No**

Render Care in FQHC/RHC = **No**

Include MCO Encounters = **Yes**

Figure 10: Selection Criteria for Choosing to Include Managed Care Organization (MCO) Encounters

Include Organization Encounters ? ☐ Yes ☒ No

Render care in FQHC/RHC ? ☐ Yes ☒ No

Include MCO Encounters ? ☒ Yes ☐ No

Managed Care Encounters

Total Managed Care Encounters: ?

Total Unduplicated Encounters: ?

Total Medicaid Managed Care Encounters: ?

Total Unduplicated Medicaid Fee-For-Service Encounters: ?

Under this scenario, you are electing to include your managed care encounters. You must provide managed care encounters for both Medicaid and total (all payers including Medicaid).

Total Managed Care Encounters (1): These are all your managed care encounters, including private and Medicaid. You may not have any private managed care encounters.

Total Unduplicated Encounters (2): All non-managed care based encounters. This includes Fee-For-Service Medicaid, private insurance, etc.

Total Medicaid Managed Care Encounters (3): All Maryland Medicaid MCO encounters.

Total Unduplicated Medicaid Fee-For-Service Encounters (4): All Maryland Medicaid Fee-For-Service encounters.

To get your Medicaid patient volume do the following: $(3+4) / (1+2)$ = percent of total encounters that are Medicaid.

Scenario 4:

Include Organization Encounters = **No**

Render Care in FQHC/RHC = **Yes**

Include MCO Encounters = **No**

Figure 11: Selection Criteria for Choosing Rendering Care in an FQHC

The form is titled "Selection Criteria for Choosing Rendering Care in an FQHC". It contains three radio button groups at the top, each with a question mark icon. The first group is "Include Organization Encounters" with "Yes" and "No" options; "No" is selected. The second group is "Render care in FQHC/RHC" with "Yes" and "No" options; "Yes" is selected. The third group is "Include MCO Encounters" with "Yes" and "No" options; "No" is selected. Below these are two sections with rounded borders. The first section is titled "FQHC/RHC Encounters" and contains five rows, each with a label and a text input field followed by a question mark icon: "Total Encounters:", "Medicaid Encounters:", "CHIP Encounters:", "Charity Care Encounters:", and "Sliding Fee Scale Encounters:". The second section is titled "All Other Settings Encounters" and contains two rows: "Total Encounters:" and "Medicaid Encounters:", each with a text input field and a question mark icon.

Providers who practice predominantly in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) are allowed to include some additional types of encounters in their eligible patient volume. In this scenario, providers must supply encounter numbers both in the FQHC or RHC and outside the FQHC or RHC (in the “All Other Settings Encounters” section). If a provider only practices in an FQHC or RHC, you can enter zeros in the “All Other Settings Encounters” section.

An EP “practices predominantly” at an FQHC or an RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months occurs at an FQHC or RHC. Providers can only use these additional types of encounters, i.e. charity care and sliding fee scale encounters, if they meet this requirement.

Scenario 5:

Include Organization Encounters = **Yes**

Render Care in FQHC/RHC = **Yes**

Include MCO Encounters = **N/A**

Figure 12: Selection Criteria for Choosing Rendering Care in an FQHC and Participating Using “Group Proxy”

The screenshot shows a web form for selecting rendering care criteria. At the top, there is a section titled "Include Organization Encounters" with a question mark icon and two radio buttons: "Yes" (selected) and "No". Below this is a section titled "Organization NPI" with a text input field and a question mark icon. The next section is titled "Render care in FQHC/RHC" with a question mark icon and two radio buttons: "Yes" (selected) and "No". Below this is a section titled "FQHC/RHC Encounters" with five rows of text input fields, each with a question mark icon. The rows are labeled: "Total Encounters:", "Medicaid Encounters:", "CHIP Encounters:", "Charity Care Encounters:", and "Sliding Fee Scale Encounters:".

Under this scenario, you are electing to use your Practice/Organization’s encounter numbers as a proxy. You will need to provide the group or organization NPI that you are using as a proxy and the Practice/Organization’s encounter numbers.

To ensure that Medicaid has collected all group members before reviewing your attestation, you should upload your group roster for the patient volume period (see page 10). If you do not upload your roster, Medicaid will contact you via the email address available under the "Federal Information" tab (see page 8).

Note: You should include MCO Encounters when calculating total and Medicaid encounters. If you select this option, you are also attesting to meeting the requirement for practicing predominantly in an FQHC or RHC in order to use the FQHC or RHC organization’s volume as proxy. Also, please review the criteria described in Scenarios 2 and 4.

Scenario 6:

Include Organization Encounters = **No**

Render Care in FQHC/RHC = **Yes**

Include MCO Encounters = **Yes**

Figure 13: Selection Criteria for Choosing Rendering Care in an FQHC and Including MCO Encounters

Include Organization Encounters ☐ Yes ☒ No

Render care in FQHC/RHC ☒ Yes ☐ No

Include MCO Encounters ☒ Yes ☐ No

FQHC/RHC Encounters

Total Encounters: ?

Non-Panel Medicaid Encounters: ?

CHIP Encounters: ?

Charity Care Encounters: ?

Sliding Fee Scale Encounters: ?

All Other Settings Encounters

Total Encounters: ?

Medicaid Encounters: ?

Managed Care Encounters

Total Managed Care Encounters: ?

Eligible Patient Panel: ?

In this scenario, you are selecting that you are practicing in an FQHC or RHC, have additional encounters in another setting, and also see Medicaid Managed Care patients.

Note: Please review the criteria described in Scenario 4.

All providers also have the option of including encounters from other states. If you select this option, you will be asked what other states were included. The inclusion of out-of-state encounters is optional and will initiate an eligibility verification audit. Medicaid staff will contact you for additional information and may contact the other state(s) to confirm encounter data; this will likely delay payment.

About the EHR Certification ID Number

During attestation, CMS requires each eligible professional to provide a CMS EHR Certification ID that identifies the certified EHR technology being used to demonstrate Meaningful Use. This unique CMS EHR Certification ID or Number can be obtained by entering the certified EHR technology product information at the Certified Health IT Product List (CHPL) on the [ONC Website](https://chpl.healthit.gov).

Note: The ONC CHPL Product Number issued to your vendor for each certified technology is different than the CMS EHR Certification ID. Only a CMS EHR Certification ID obtained through CHPL will be accepted at attestation.

Eligible professionals can obtain a CMS EHR Certification ID by following these steps:

1. Go to the ONC CHPL website: <https://chpl.healthit.gov>
2. In the search box, you can choose to search by Product Name, Vendor Name, or CHPL Product Number.
3. Filter the search results according to the following filtering criteria: Certification Edition, Practice Type, Classification, Certified Criteria, and Certified CQMs.
4. Click on the check box next to the product desired to finalize the selection.
5. Select 'See Progress' to view the Progress page and view current status in relation to meeting necessary requirements to obtain a CMS EHR Certification ID.
6. Click on the 'Get Certification ID' button and the CHPL will generate and display a CMS EHR Certification ID which is representative of the combination of products selected.

Note: The "Get CMS EHR Certification ID" button will NOT be activated until the products selected meet 100% of the CMS required criteria. If the EHR products do not meet 100% of the CMS required criteria to demonstrate Meaningful Use, a CMS EHR Certification ID will not be issued. You may use [this link](#) to access a walk through document to generate a CMS EHR Certification ID using the CHPL website.

MU Reporting Choice

To receive an EHR Incentive Program payment, providers have to show that they are 'meaningfully using' their certified Electronic Health Record technology by meeting certain measurement thresholds that range from recording patient information as structured data to exchanging summary records.

CMS has established these thresholds for eligible professionals, eligible hospitals, and critical access hospitals.


[View information about Modified Stage 2 Program Requirements](#)

[View information about Stage 3 Program Requirements](#)

In the MU Reporting Choice drop down list, you will select the Stage of Meaningful Use you wish to attest to for the current Program Year.

Meaningful Use for Eligible Professional




If you are participating in at least your second year with the Medicaid EHR Incentive Program, you will be able to click on the tab “Meaningful Use.” This tab shows a summary of your Meaningful Use information with the state.

The  icon shows the year of participation with the EHR Incentive Programs followed by the start and end date for your Meaningful Use period. Your Meaningful Use period is either: (1) any continuous 90-day period in the calendar year or (2) a full 365-days.

This tab also shows the status of your Meaningful Use measures. If you have entered a valid value or selected exclusion for the number of Core/MU, Menu/PH, and Clinical Quality Measures (CQM) required under Meaningful Use for your year of participation, you will see the word “Complete” under the appropriate heading. If not, you will see the word “Incomplete.”

Click on the  icon to enter Meaningful Use information.

Figure 14: Eligible Professional Meaningful Use Attestation Icon

FEDERAL INFORMATION		ELIGIBILITY		MEANINGFUL USE		
Year	Program Year	Start Date	End Date	Core/MU	Menu/PH	CQM
 4	2015	01/01/2015	03/31/2015	Complete	Complete	Complete
 3	2014	04/01/2014	06/29/2014	Complete	Complete	Complete
 2	2013	07/31/2013	10/29/2013	Complete	Complete	Complete

Meaningful Use Overview

When you click on the icon, you will be shown a page containing: (1) information about choosing your Meaningful Use period; (2) information about choosing your Meaningful Use CQM period; and (3) a system-generated check list showing your Meaningful Use status. Throughout the Meaningful Use web tool, you will see yellow notes providing helpful information.

Figure 15: Eligible Professional Meaningful Use Overview Screen

Meaningful Use Information

MU-Overview Summary MU-Objectives MU-Public Health MU-Clinical Quality Measures Set

— Meaningful Use Reporting Period —

Start Date: 01/01/2017

End Date: 03/31/2017

Reporting Period

Enter reporting period Start Date and the End Date will automatically populate. This is a 90 day period in the current program year (2017).

— Meaningful Use CQM Reporting Period —

Start Date: 01/01/2017

End Date: 03/31/2017

CQM Reporting Period

Enter reporting period Start Date and the End Date will automatically populate. This is a 90 day period in the current program year (2017) and CQM reporting can be different than the reporting period for Meaningful Use.

— Meaningful Use Reporting Completion —

Checklist

- ☒ MU Objectives
- ☒ MU PH Measures
- ☒ MU CQM Measures

Check

When each component of meaningful use reporting is complete, the system will check the corresponding checkbox.

Click on the Save button to save the data.

Maryland must review Meaningful Use supporting documents before approving attestations for Years 2 to 6. Before submitting your attestation, please upload the Meaningful Use documents on the [Attestation Checklist](#) to the Upload Document section.

Save Cancel

Step 1: Enter Meaningful Use Reporting Period

Select a reporting period that encompasses any continuous 90-day reporting period within the calendar year 2018. Enter your begin date. Once you enter the begin date, the system will automatically end date your Meaningful Use period. Information on the Meaningful Use reporting periods is available in the [Frequently Asked Questions](#) section of this document.

Step 2: Enter Meaningful Use CQM Reporting Period

Select a reporting period that encompasses any continuous 90-day or greater reporting period within the calendar year 2018. In 2018, you are able to select a 90-day or greater reporting period in the current calendar year for CQMs that differs from your reporting period for Meaningful Use.

Step 3: Save

Please save your information by clicking the Save button at the bottom left of the screen.

If you would like to fill out your Meaningful Use Information online, select the third tab at the top of this page, “MU-Objectives”.

Meaningful Use Objectives

The page in Figure 16 below shows an example of the Meaningful Use Objectives required by CMS for Eligible Professionals. Depending on what Stage of Meaningful Use you are in, you may see different Objectives. Eligible Professionals must meet or claim a valid exclusion for all objectives listed in the Meaningful Use set. On the right-hand side of this page, the system summarizes your status meeting the requirements. For example, this particular provider has filled out Meaningful Use information for 9 out of the required 9 Meaningful Use objectives.

To see the details on any objective, just move your cursor over the objective and click. See Figure 17 for details.

Figure 16: Eligible Professional Meaningful Use Objectives Set Screen

Meaningful Use Objectives - EPs must fill out all 9 Meaningful Use Objectives.

❗ - Objective Not Completed Yet ✅ - Objective Completed

▶ Objective 1: Protect Patient Health Information	✅
▶ Objective 2: Clinical Decision Support	✅
▶ Objective 3: Computerized Provider Order Entry	✅
▶ Objective 4: Electronic Prescribing	✅
▶ Objective 5: Health Information Exchange	✅
▶ Objective 6: Patient-Specific Education	✅
▶ Objective 7: Medication Reconciliation	✅
▶ Objective 8: Patient Electronic Access (VDT)	✅
▶ Objective 9: Secure Electronic Messaging	✅

Note: The system accepts any mathematically valid entry. A completed objective, as signified by the ✅ icon, does not necessarily mean that you have passed the measure. It means you have completed the objective by entering information.

Note: You can learn about the Centers for Medicare and Medicaid Services' (CMS) [Final Rule](#) that changes the Meaningful Use requirements for providers and hospitals in 2018 by reviewing Maryland Medicaid's newsletter, [E-Connect](#).

Figure 17: Eligible Professional Meaningful Use Objective Selection

Objective 3: Computerized Provider Order Entry

Objective
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

Measure 1
More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 2
More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 3
More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

— Measure 1 Exclusion —
Exclusion Applies to you? ☐ Yes ☒ No
Exclusion Value:
Exclusion

— Measure 1 Compliance —
Numerator 1:
Denominator 1:
Compliance

— Measure 2 Exclusion —
Exclusion Applies to you? ☐ Yes ☒ No
Exclusion Value:
Exclusion

— Measure 2 Compliance —
Numerator 2:
Denominator 2:
Compliance

— Measure 3 Exclusion —
Exclusion Applies to you? ☐ Yes ☒ No
Exclusion Value:
Exclusion

— Measure 3 Compliance —
Numerator 3:
Denominator 3:
Compliance

Show All Descriptions

Figure 17 shows an example of the detail page for **Objective 3: CPOE for Medication, Laboratory, and Radiology Orders**. All of the objectives have similar pages. In this example, a provider may claim a valid exclusion or submit an appropriate numerator and denominator to meet the threshold for this objective. Information on the objective, how it is measured (*i.e.*, what patients are counted to arrive at the percentage and the required threshold) are listed on the left-hand side of the page. The exclusion criteria can be viewed by clicking on the (?) Exclusion on the right-hand side of the page. The appropriate information will be available for every objective.

On the right-hand side of the page, the system provides more detailed information about how to fill out the text boxes. If invalid information is entered, the system will return an error message with a description of the error. **The system does not validate whether the numbers entered meet the threshold value. They only ensure that the denominator is greater than or equal to the numerator.**

Providers can fill out all required information for the Objective at once, or they can save their progress and return at a later time.

Note: If at any time you change information on any objective, please save your information by clicking on the Save button at the bottom left-hand side of the screen.

Meaningful Use Public Health Reporting

The requirements for meeting the Meaningful Use Public Health Objective are listed under the “MU-Public Health” tab. The consolidated public health objective has three measure options: Immunization Data Registries Submission, Syndromic Surveillance Reporting and Specialized Registry Reporting. The options for the Specialized Registry Reporting include Cancer, Prescription Drug Monitoring Program, or case reporting via Consolidated Clinical Document Architecture (CCDA). More information about these options can be obtained by emailing mdh.mu_ph@maryland.gov.

To increase the likelihood that providers submit data to the State's public health registries, Maryland has modified the public health requirement by establishing an order or precedence for public health reporting. If providers engage with Maryland Medicaid and the State's Health Information Exchange ("HIE"), CRISP, to submit cases to public health via CCDA, Maryland will count this action towards meeting "active engagement".

Examples of the public health reporting measures you will see are available in Figure 18. In Modified Stage 2 and Stage 3, EPs will need to meet at least two measures to be compliant. On the right-hand side of this page, the system summarizes your status with meeting the reporting options.

To see the details on any measure option, just move your cursor over the measure and click. Each Public Health Measure's page is similar to each Meaningful Use Objective's page. See page 23 for an example of a Meaningful Use Objective page.

Figure 18: Eligible Professional Meaningful Use Public Health Objective

MU-Overview Summary MU-Objectives **MU-Public Health** MU-Clinical Quality Measures Set

Meaningful Use Public Health Objective - Providers will need to report for each of the public health measures in an order of precedence. They will need to either attest to the measure, claim an exclusion, or claim an alternate exclusion for each measure before proceeding to the next. EPs will need to meet at least 2 measures to be compliant. EPs in Stage 2 2015 can claim alternate exclusions for Syndromic Surveillance or Specialized Registry reporting, or both. If the EP claims alternate exclusions for both Syndromic Surveillance and Specialized Registry reporting, they must either meet the Immunization Registry reporting measure or claim an exclusion.

🚫 - Objective Not Completed Yet ✅ - Objective Completed

- ▶ Measure 1: Immunization Registries Data Submission ✅
- ▶ Measure 2: Syndromic Surveillance Reporting ✅
- ▶ Measure 3: Specialized Registry Reporting ✅

Note: If at any time you change information on any objective, please save your information by clicking on the Save button at the bottom left-hand side of the screen.

Meaningful Use Clinical Quality Measures Set

Requirements for meeting the Meaningful Use Clinical Quality Measures Set (CQMs) are listed under the Meaningful Use tabs. On the right-hand side of this page, the system summarizes your status meeting the requirements.

Providers must report any six CQMs relevant to their scope of practice, regardless of whether they report by attestation or electronically and regardless of participation year. Use your most recent version of CQMs from your EHR to attest. The version from your EHR may differ from the version in eMIPP, which is for the 2017 reporting period from the CMS eCQM Library. To see the details on any domain or measures, just move your cursor over the domain or measure, and click. Each Clinical Quality Measure is similar to the others. Detailed instructions appear when you select any one of the Clinical Quality Measures.

Figure 19: Eligible Professional Meaningful Use Clinical Quality Measures Screen

Meaningful Use Information

MU-Overview Summary MU-Objectives MU-Public Health MU-Clinical Quality Measures Set

Meaningful Use Clinical Quality Measures -
Providers must report six CQMs relevant to their scope of practice. The 53 available CQMs below align with those available to clinicians participating in MIPS who submit electronic CQMs.
The version numbers for CQMs in your EHR may differ from the version number in eMIPP, which is for the 2017 reporting period from the CMS eCQM Library. Please use the most recent version of CQMs available in your EHR to attest.
You may now report clinical quality measures (CQMs) to eMIPP electronically. Integrated with Maryland's state-designated health information exchanges (CRISPs) [CQM Aligned Population Reporting \(CALiPR®\)](#), eMIPP provides a one-click electronic CQM reporting option for participants in the Medicaid EHR Incentive Program. Providers/eMIPP users may upload multiple QRDA category III files (machine readable/xml eCQM results files) to CALiPR, and export the data electronically to eMIPP when ready to attest. For more information on CALiPR, please click [here](#). To sign up and report eCQMs electronically, please email cali-pr-helpdesk@crisphealth.org

☐ Import from CALiPR

❗ - Objective Not Completed Yet ✅ - Objective Completed

Domain 1 - Person and Caregiver-Centered Experience and Outcomes

These are CQMs that reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient reported data and the ability to impact care at the individual patient level as well as the population level through greater involvement of patients and families in decision making, self care, activation, and understanding of their health condition and its effective management.

▶ CMS56v5: Functional Status Assessment for Total Hip Replacement	✅
▶ CMS56v5: Functional Status Assessment for Total Knee Replacement	✅
▶ CMS90v6.2: Functional Status Assessments for Congestive Heart Failure	✅
▶ CMS157v5.2 / NQF0384: Oncology: Medical and Radiation - Pain Intensity Quantified	❗

▶ Domain 2 - Patient Safety


▶ Domain 3 - Communication and Care Coordination

▶ Domain 4 - Community/Population Health

▶ Domain 5 - Efficiency and Cost Reduction

Note: If at any time you change information on any objective, please save your information by clicking on the Save button at the bottom left-hand side of the screen.

Upload Supporting Documentation

eMIPP allows providers to upload supporting documentation at any time of the attestation review process. Once you have selected the “Upload Document” tab, you can move your cursor to the upload icon  to upload information concerning your attestation.

Because every provider could be potentially selected for a post-payment audit, providers should have auditable proof that they meet patient volume qualifications. Medicaid recommends that you have an electronic, searchable file, such as Excel, that provides the following information:

- Provider name or identification number;
- Recipient name or identification number;
- Date of service;
- Place of service
- Payment status (paid or not paid)
- Payer type (Medicaid, private, Medicare, self-pay, etc.); and
- Payer name (Blue Cross Blue Shield, Medical Assistance, Priority Partners, etc)

To reduce the need for any post-payment audit, Medicaid recommends that you submit this information (or some auditable record proving that you meet patient volume requirements) at this stage in your registration.

As part of the pre-payment audit process, Medicaid requires that providers upload:

- An EHR-system generated report showing your objects and measures;
- A copy of the [Security Risk Assessment](#);
- Screenshots that show FIVE clinical decision support (CDS)
- Screenshots of drug-drug and drug-allergy interaction checks; and
- Supporting documentation for exclusions.

Figure 20: Upload Supporting Documentation Screen

FEDERAL INFORMATION	ELIGIBILITY	MEANINGFUL USE	UPLOAD DOCUMENT	Payment Year	Program Year	Payee NPI	View	Upload
				4	2015	1111111111		
				3	2014	1111111111		
				2	2013	1111111111		
				1	2011	1111111111		

When you select the upload icon, you will see the following pop-up screen. The eMIPP system will allow you to upload text files, word documents, Excel spreadsheets, and PDFs, among others. Simply click the “Choose File” button to select your file. Before uploading the document, you will need to provide a description of the file. Please be as specific as possible.

You can upload as many documents as you would like. Once a document is uploaded, it cannot be deleted.

Figure 21: Selecting Supporting Documentation to Upload










After uploading your document, you can click the view icon  to see a list of all the documents you have uploaded. From the document list, you can view your comments or download the files you have uploaded.

Figure 22: View Uploaded Supporting Documentation

FEDERAL INFORMATION	ELIGIBILITY	MEANINGFUL USE	UPLOAD DOCUMENT	Payment Year	Program Year	Payee NPI	View	Upload
				4	2015	1111111111		
				3	2014	1111111111		
				2	2013	1111111111		
				1	2011	1111111111		

Submit to State

1. Read the terms and conditions, then do the following:
 - a. Select the printer icon to print the agreement if needed.
 - b. Click the checkbox to agree.
 - c. Click **Register** to submit the application. A pop-up box will ask for verification to submit the application.
 - d. Click **OK** to submit or **Cancel** to return to the application and make changes.

Note: After submitting the application, you cannot make changes. However, if your attestation is rejected by the State, you may make the necessary changes and reapply. If you have attested in error, please contact Maryland Medicaid at mdh.marylandEHR@maryland.gov

Figure 23: Eligible Professional Submit Attestation to State Screen

208.91.161.51 says
Do you want to submit your EHR Registration for State Review?

OK Cancel

Home Register Track Logout

Success
We have received your registration information from the NLR. Please continue with state registration by completing tabs 1 through 3.

Search Criteria
Registration ID :
NPI :

Login Information
User ID :
Profile : Provider Domain Admin

FEDERAL INFORMATION
ELIGIBILITY
MEANINGFUL USE
UPLOAD DOCUMENT
ATTESTATION

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature

I certify that the foregoing information is true, accurate and complete. I understand that the HITECH incentive payment I requested will be paid from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws. I hereby agree to keep such records as are necessary to demonstrate that I met all HITECH requirements and to

☒ I accept the terms and conditions

Register

2. Validate that the payment information you chose during attestation is correct. Be sure to check that you have entered the correct Tax ID before submitting payment information and to double-check after submission.

Figure 24: Attestation Complete Confirmation Screen



MIPP Registration
Start Medicaid Incentive Payment (MIPP) Registration
Start

View Status of MIPP registration
View status of Medicaid Incentive Payment Registration
Track

EHR Incentive Program Registration Confirmation
Your Medicaid EHR Incentive Program registration is successfully submitted for State review.
If the below information is incorrect please contact our office at dhmh.MarylandEHR@maryland.gov.

Registration ID	: 1000111111
Name	: Doe, John
Payee NPI	: 999999999
Payee Tax ID	: 111111111
Pay to Provider	: My Practice – My Practice NPI

3. Click **Logout** to exit the application.

NOTE: Once you have submitted with the State, **DO NOT RETURN TO THE CMS WEBSITE UNLESS INSTRUCTED BY THE STATE.** Returning to this website will hinder Maryland’s ability to review your attestation. Once you have submitted with the State, you should only be interacting with the State’s system, eMIPP.

Eligible Hospital Registration and Attestation in eMIPP

Providers will receive their CMS Registration ID in the CMS registration (Step 1(b) on page 6). You cannot sign in to the site without this number. Log in to the Maryland EHR Registration and Attestation System.

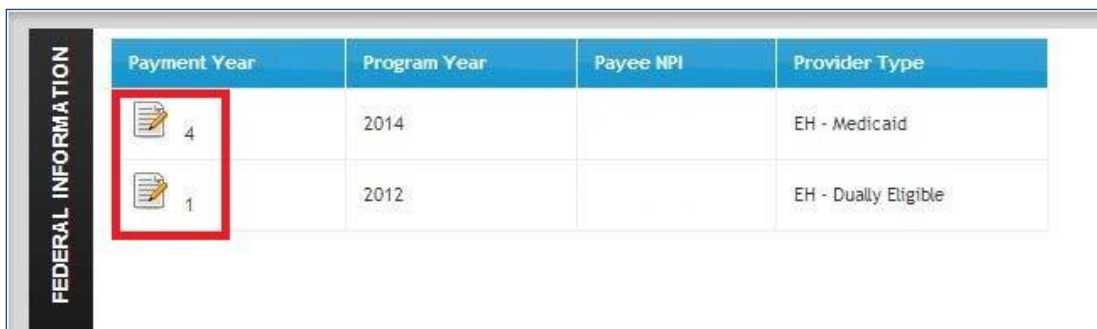
1. Login with eMedicaid username and password and click **Submit**.
2. On the next screen, select **Go**.
3. Under MIPP Registration, select **Start**.
4. Enter your 10-digit CMS Registration ID; select **Search**.



Figure 25: Hospital CMS Certification Number Submission Screen



5. On the next screen, you will see a page with three tabs. By default, you will begin on Tab 1, **FEDERAL INFORMATION**. Review the information and select the icon for the year in which you are participating in the program.

Figure 26: Hospital Federal Information Verification Screen



Payment Year	Program Year	Payee NPI	Provider Type
 4	2014		EH - Medicaid
 1	2012		EH - Dually Eligible

On this tab, you need to review and confirm the information from the CMS Registration and Attestation System. If there are any issues with the information that need to be corrected, STOP and go back to the CMS website and correct the issue(s). Wait at least one full business day before accessing eMIPP. . If the updated information is displayed, you can continue. If not, wait one more day and try again. If the new information is not displayed, call the EHR Incentive Program Information Center at (888) 734-6433, or TTY (888) 734-6563.

- After reviewing the information on Tab 1, click on Tab 2, **ELIGIBILITY**.

Figure 27: Hospital Eligibility Determination Selection Screen

ELIGIBILITY

Payment Year	Program Year	Certification Number	EHR Status
3	2018		Meaningful Use
2	2014		Meaningful Use
1	2013		Meaningful Use

To expedite the review of your attestation, please upload documentation that supports the patient encounters you report. More information is available on the [Attestation Checklist](#)

- Enter **Eligibility Information**.

Figure 28a: Hospital Eligibility Determination Submission Screen

Eligibility Information ✕

Bold fields are required.

Eligibility Information

Patient Volume Reporting Period

Start Date :

?

End Date :

?

Encounter Information

Medicaid Encounters :

?

Total Encounters :

?

Pay To Provider

Select Pay To Provider

---SELECT---

The Pay To Provider represents the Maryland Medicaid account to which the incentive payment will be directed upon approval. If no options are available for selection, or if the options available for selection are incorrect, please email mdh.marylandehr@maryland.gov

EHR Certification Information

EHR Status

?

☒ MU

EHR Certification Number:

A014E01GYWC2EAB

?

Email: mdh.marylandehr@maryland.gov

Save

Cancel

Figure 28b: Hospital Eligibility Determination Submission Screen

EHR Certification Information

EHR Status ☒ MU

EHR Certification Number:

Email: mdh.marylandehr@maryland.gov

Reporting Period: The default start date is today's date. Enter the start date (in MM/DD/YYYY format) that you want to start your eligibility reporting period. This is not your Meaningful Use reporting period in 2018; it is the continuous 90-day period in the prior federal fiscal year (between October 1, 2017 and September 30, 2018) that you are reporting your eligible/Medicaid patient volume. Once you fill in the start date, click in the end date field and the system will automatically fill in the end date. **Note:** Both the start and end date must be in the prior federal fiscal year—it cannot span multiple years. Your reporting period can be any consecutive 90-day period within the prior fiscal year. To ensure your hospital's eligibility, each hospital should contact MDH to obtain patient volume information before attesting. Hospitals can receive their patient volume information by emailing MDH at mdh.MarylandEHR@maryland.gov.

EHR Status: Select the appropriate EHR Status for your hospital. If you are a dually-eligible hospital and have already attested for the Medicare EHR Incentive Program, you will have the option to select "MU" (Meaningful Use). If you are participating in your second year with Medicaid or if you selected Meaningful Use in your first year, the only option you will have is to select "MU."

EHR Certification Number: The CMS EHR Certification ID is made up of 15 alphanumeric, case sensitive characters and should be entered in ALL UPPER CASE.

8. Click **Save**.

9. Submit Meaningful Use.

NOTE: You will need to re-submit the Meaningful Use measures you originally submitted to Medicare to Maryland Medicaid. Please email MDH at mdh.MarylandEHR@maryland.gov for more information on submitting Meaningful Use information for a hospital.

10. Upload supporting documentation.

All hospitals should upload any documentation as indicated in communication with MDH to eMIPP prior to submitting their attestation. See page 27 for details on uploading supporting documentation.

11. Attestation.

Read the terms and conditions, then do the following:

- (1) Select the printer icon to print the agreement, if needed.
- (2) Click the checkbox to agree.
- (3) Click **Register** to submit the application. A pop-up box will ask for verification to submit the application.
- (4) Click **OK** to submit or **Cancel** to return to the application and make changes.

Note: After submitting the application, you cannot make changes. However, if your attestation is rejected by the State, you may make the necessary changes and reapply. If you have attested in error, please contact Maryland Medicaid at mdh.MarylandEHR@maryland.gov.

Figure 29: Hospital Attestation Submission Screen

The screenshot displays the 'Hospital Attestation Submission Screen' on the eMIPP portal. At the top, the Maryland Department of Health logo is on the left, and the eMIPP logo is on the right. A central pop-up box from IP address 208.91.161.51 asks, 'Do you want to submit your EHR Registration for State Review?' with 'OK' and 'Cancel' buttons. Below this is a navigation bar with 'Home', 'Register', 'Track', and 'Logout' links. The main content area is divided into three sections: 'Success' (with a green checkmark icon and a message about receiving registration information), 'Search Criteria' (with input fields for 'Registration ID' and 'NPI'), and 'Login Information' (showing 'User ID' and 'Profile: Provider Domain Admin'). The bottom section is the 'ATTESTATION' form, which includes a 'NOTICE' about false claims, a 'Signature' field with a text area for a certification statement, a checkbox for 'I accept the terms and conditions', a 'Register' button, and a printer icon.

12. Review confirmation.

After attesting with the State, please validate that the payment information you chose during attestation is correct.

Figure 30: Hospital Attestation Complete Confirmation Screen

MIPP Registration
Start Medicaid Incentive Payment (MIPP) Registration
Start

View Status of MIPP registration
View status of Medicaid Incentive Payment Registration
Track

EHR Incentive Program Registration Confirmation
Your Medicaid EHR Incentive Program registration is successfully submitted for State review.
If the below information is incorrect please contact our office at dhmh.MarylandEHR@maryland.gov.

Registration ID : 1000111111
Name : Doe, John
Payee NPI : 999999999
Payee Tax ID : 111111111
Pay to Provider : My Practice – My Practice NPI

13. Click **Logout** to exit the application.

NOTE: Once you have submitted with the State, **DO NOT RETURN TO THE CMS WEBSITE UNLESS INSTRUCTED BY THE STATE.** Returning to this website will hinder Maryland's ability to review your attestation. Once you have submitted with the State, you should only be interacting with the State's system, eMIPP.

Track Registration Submission

1. Login with eMedicaid username and password and click **Submit**.
2. On the next screen, select **Go**.
3. Under eMIPP Registration, select **Track**.
4. Enter your 10-digit CMS Registration and Attestation ID; select **Search**
5. View the status of the submission. The green check marks indicate a completed step. The gears and green arrow indicate the current status.

Figure 31: Track Application Status Bar



Generally, submitted attestations will stay in the “State Review” status for an average of 45 days. During this time, the State is validating your information. If, after 45 days you have not received a follow up e-mail from the State, please contact us at mdh.MarylandEHR@maryland.gov. Please include your CMS Registration ID in either the subject line or body of your e-mail.

Troubleshooting Issues

Error: Invalid Sign In

Action: You have not used the correct username and password. The username and password is the same as the eMedicaid login. If you have not registered at the [eMedicaid portal](#), please do so first, then try logging in again.

Error: Error Communicating to the Web Service for Authentication.

Action: The application is having trouble communicating with the State Web service to authenticate your username and password. Wait and try again.

Error: Invalid Registration Details – The Maryland domain you are using does not match the CMS Registration ID.

Action: There is a mismatch between the NPI that you used to register in eMedicaid and the NPI that you used to register with CMS. You will need to contact Provider Enrollment at 410-767-5503 to make necessary corrections and try again.

Error: Invalid Registration Details – CMS Registration ID not found. Please check your ID and enter again. If this issue persists upon re-entering, contact CMS to verify your Registration ID.

Action: You have not entered the correct CMS registration ID, please check your welcome letter for the correct CMS registration ID and try again.

Error: Invalid Registration Details – You are currently either not an active Maryland Medicaid Fee- For- Service (FFS) provider or you are not an eligible provider type for the EHR Incentive Program. You may not begin your Maryland EHR registration unless you meet both of these criteria. If you do not address the issue within 30 days, your Maryland EHR registration will be denied.

Action: Visit [ePREP](#) to view or amend your enrollment status. For assistance, call 1.844.4MD.PROV (1.844.463.7768)

Frequently Asked Questions

What are the 2018 program requirements?

On October 6, 2015, CMS released the [2015-2017 Modifications and Stage 3 Final Rule](#). The rule creates a single set of objectives and measures; sets the calendar year as the program year for EPs and EHs; and provides a transitional approach to meeting MU.

How do objectives and measures change under the Final Rule?

The final rule restructures Modified Stage 2 MU core and menu sets of objectives and measures to incorporate a single set of ten required objectives including one consolidated public health objective for EPs and a single set of nine required objectives including one consolidated public health objective for Medicaid-only EHs and a single set of seven required objectives including one-consolidated public health objective for dually eligible EHs. It also updates threshold calculations and compliance checks.

The final rule has also established changes to specific objectives for Meaningful Use program requirements for both EPs and EHs:

For EPs attesting to Modified Stage 2, the final rule has made changes to Objective 8, Measure 2, Patient Electronic Access: For an EHR reporting period in 2018, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit their health information to a third party during the EHR reporting period.

The final rule also changed EPs' Modified Stage 2 Objective 9, Secure Messaging: For an EHR reporting period in 2018, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

For Dually-Eligible Hospitals attesting to Modified Stage 2, they will see a change in Objective 6, Measure 1, Patient Electronic Access, Provide Patient Access: For an EHR reporting period in 2018, the health information for more than 50% of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of a dually-eligible hospital or CAH must be provided for timely access to view online, download and transmit to a third party.

For Medicaid-only Eligible Hospitals attesting to Modified Stage 2, they will also see changes in Objective 8, Measure 2, Patient Electronic Access: For an EHR reporting period in 2018, more than 5 percent of unique patients discharged from the inpatient or emergency

department (POS 21 or 23) of an Medicaid-only eligible hospital or CAH (or patient-authorized representative) view, download or transmit to a third party their health information during the EHR reporting period.

The Final rule also established Stage 3 Meaningful Use requirements. For Stage 3 MU, all providers are required to attest to a single set of objectives and measures. For eligible professionals (EPs) and Medicaid-only eligible hospitals (EHs) there are 8 objectives. For dually-eligible hospitals (EHs), there are 6 objectives.

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 3, Measure 1, Patient Electronic Access, Provide Patient Access: For an EHR reporting period in 2018, for more than 50% of all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23): (1) the patient (or the patient-authorized representative) is provided timely access to view, download, or transmit (VDT) his or her health information; and (2) the provider ensures the patient's health information is available for the patient (or patient authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the application programming interfaces (APIs) in the provider's CEHRT

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 3, Measure 2. Patient Electronic Access, Patient Specific Education: For an EHR reporting period in 2018, the eligible hospital or CAH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 10 percent of unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 4, Measure 1, Coordination of Care through Patient Engagement, View, Download, or Transmit: For an EHR reporting period of 2018, at least one unique patient (or their authorized representatives) discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) actively engages with the EHR made accessible by the provider and engages in one of the following: (1) VDT to a third party their health information; or (2) access their health information through the use of a API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 4, Measure 2, Coordination of Care Through Patient Engagement, Secure Messaging: For an EHR reporting period of 2018, at least 5 percent of all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the

EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in a response to a secure message sent by the patient (or the patient-authorized representative).

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 5, Measure 1, Health Information Exchange, Send a Summary of Care: For an EHR reporting period of 2018, for at least 10 percent of transitions of care and referrals, the eligible hospital or CAH that transitions or refers their patient to another care setting or provider: (1) created a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 5, Measure 2, Health Information Exchange, Request/Accept Summary of Care: For an EHR reporting period of 2018, for at least 10 percent of transactions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH incorporates into the patient's EHR an electronic summary of care document.

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 5, Measure 3, Health Information Exchange, Clinical Information Reconciliation: For an EHR reporting period of 2018, for more than 50 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH performs a clinical information reconciliation. The eligible hospital or CAH must implement clinical information reconciliation for the following three clinical information sets: (1) medication: review of the patient's medication, including the name, dosage, frequency and route of each medication; (2) medication allergy: review of the patient's known allergic medications; and (3) current Problem list: review of the patient's current and active diagnoses.

For Dually-Eligible Hospitals attesting to Stage 3, they will see a change in Objective 6, Public Health Reporting: For an EHR reporting period of 2018, the reporting requirement is a combination of any three required public health measures.

To meet Stage 3 requirements, all providers must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. However, a provider who has technology certified to the 2014 Edition only may not attest to Stage 3.

Stage 3 includes flexibility within certain objectives to allow providers to choose the measures most relevant to their patient population or practice. The Stage 3 objectives with flexible measure options include:

- **Coordination of Care through Patient Engagement** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Health Information Exchange** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Public Health Reporting** – Eligible professionals must report on two measures and eligible hospitals must report on four measures.

What is the timeline for reporting MU information?

Providers must demonstrate Meaningful Use for any continuous 90-day EHR reporting period. Providers who participate in the Medicaid EHR Incentive Programs are not required to demonstrate Meaningful Use in consecutive years as described by the table below. In 2017, providers will have the option to attest for Modified Stage 2 or Stage 3. For Program Year 2018, EPs and EHs have the option of attesting to either Meaningful Use Modified Stage 2 or Stage 3. For Program Years 2019 through 2021, all providers must transition to Stage 3. The table below illustrates the progression of Meaningful Use stages from when a Medicare provider begins participation in the program.

First Year Demonstrating Meaningful Use	Stage of EHR Incentive Programs								
	2011	2012	2013	2014	2015	2016	2017	2018	2019 and Future Years*
2011	Stage 1	Stage 1	Stage 1	Stage 1 or Stage 2	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2012	N/A	Stage 1	Stage 1	Stage 1 or Stage 2	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2013	N/A	N/A	Stage 1	Stage 1	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2014	N/A	N/A	N/A	Stage 1	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2015	N/A	N/A	N/A	N/A	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2016	N/A	N/A	N/A	N/A	NA	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2017	N/A	N/A	N/A	N/A	NA	NA	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2018	N/A	N/A	N/A	N/A	NA	NA	NA	Modified Stage 2 or Stage 3	Stage 3
2019 and Future Years	N/A	N/A	N/A	N/A	NA	NA	NA	NA	Stage 3

Where can I learn more about the changes to MU requirements under the Final Rule?

You can learn more about the Final Rule that changes the Meaningful Use requirements for Program Year 2018 and Program Years 2019 - 2021, as well as other important policy updates and useful resources for providers and hospitals who are participating in the EHR Incentive Program from [Maryland Meaningful Use Resource Center](#), or our newsletter, [E-Connect](#). To subscribe to Maryland Medicaid's E-Connect, please email mdh.MarylandEHR@maryland.gov.